

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020768

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED JUN 7 1962

Primary Registration District

1003

Registrar's No.

5543

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION 4757 Cupples

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY

Inside Limits

Yes ☐ No ☐c. CITY
OR
TOWN St. Louis

d. STREET ADDRESS (If outside, give location)

4757 Cupples

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Joseph (Joe) Montgomery

4. DATE
OF
DEATH

Month

Day

Year

5- 30- 62

5. SEX

Male

6. COLOR OR RACE

Col.

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

3-27-09

9. AGE (last birthday)

53

IF UNDER 1 YEAR IF UNDER 24 HR.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maintenance

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Pilot, Grove, Mo.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

William Montgomery

13b. MOTHER'S MAIDEN NAME

Maude Thompson

14. NAME OF HUSBAND OR WIFE

Genevieve

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

17. INFORMANT

Address

(same as above)

Mrs. Genevieve Montgomery

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☒ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Jan. 25, 1961

to

5/30/62

and last saw him alive on

5/30/62

Death occurred at

11:30 a.m.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

6-4-62

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

Pilot Grove, Mo.

State

24. FUNERAL DIRECTOR

ADDRESS

A. L. Beal Und.Co.-4303 Delmar

25. DATE RECD. BY LOCAL REG.

JUN 2 1962

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.

Dr. Williams